STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING _____ B. WING _____	R-C 03/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00104133 and IN00104251 completed on 2/23/12. This visit was in conjunction with a Post Survey Revisit (PSR) to the PSR completed on 2/9/12 to the Recertification and State Licensure Survey completed on 12/12/11 Complaint IN00104133 corrected. Complaint IN00104251 corrected. Survey date: 3/30/12 Facility number: 012329 Provider number: 155784 AIM number: 201002500 Survey team: Janelyn Kulik, RN Census bed type: SNF: 23 SNF/NF: 48 Total: 71 Census payor type: Medicare: 26 Medicaid: 29 Other: 16 Total: 71 Sample: 10 Michiana Health And Rehabilitation Center was found to be in compliance with 42 CFR Part 483,	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 000}	Continued From page 1 Subpart B and 410 IAC 16.2 in regards to the PSR to the Investigation of Complaint IN00104133 and IN00104251. Quality review completed 4/2/12 Cathy Emswiller RN	{F 000}		